

CORAL SPRINGS MONTESSORI ENROLLMENT FORM

Last 4 digits of Mom's SS# (needed for PIN #) _____

Start Date _____

Child's Name _____

Pick-up time (12, 3, 4, or 6) _____ Days of week: Mon___ Tue___ Wed___ Thu___ Fri___

Address _____

Street city state zip

Birth Date _____ Gender _____ Preferred Name _____

Mother's Name _____ (or guardian) Email Address _____

Home Address _____

Street city state zip

Home Telephone _____ mobile phone _____

Father's Name _____ (or guardian) Email Address _____

Address _____

Street city state zip

Home Telephone _____ mobile phone _____

Father or Guardian's Employment _____

Work Address _____ Telephone _____

Mother's or Guardian's Employment _____

Work Address _____ Telephone _____

Child's Physician _____

Physician Address and Phone Number _____

May the center contact another physician if unable to contact the above? _____

Responsible Party for medical bills _____

Insurance Company: Name _____ Phone _____ Insured ID Number _____

Other persons to notify and remove child in case of illness or accident (2 names required)

1. Name _____ relationship to child _____

Address _____ Phone _____

2. Name _____ relationship to child _____

Address _____ Phone _____

Persons permitted to remove child

Mother: yes__ no__ **Father:** yes__ no__

1. Name _____ relationship to child _____

Address _____ Phone _____

2. Name _____ relationship to child _____

Address _____ Phone _____

Signature of person enrolling child _____ Date _____